HOME AND COMMUNITY BASED MEDICAID WAIVER CERTIFICATION REPORT

Mountain Regional Services, Inc.

August 20–31, 2007

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Survey Outcome: One-Year Certification Expires November 30, 2008.

I. Review of Organizational Practices

A. Provider's Summary and Highlighted Service Areas:

Over the past year MRSI Evanston hosted nursing students from Western Wyoming Community College and the Rawlins Outreach Center during an internship at the Evanston site.

MRSI Cheyenne created a Day Habilitation Enhancement Program that was created in the last year. This group meets weekly to discuss how to improve the day program and has both employees and clients involved in this goal. The Director of Psychology, Director of Case Management and participants were actively involved with the election of officers to this group. MRSI Cheyenne is currently involved in the training of the agency's supervisors in "Leadership Skills" at Laramie County Community College from a grant paid by Wyoming's Workforce Development funds. This is an eight month class that meets one day each month and teaches basic skills by community leaders.

B. Results of review of policies and procedures:

a. Incident reporting

A review of MRSI'S policy on incident reporting, although updated in August of 2007, revealed that key components reflective of the Division's requirements for incident reporting were missing or incomplete.

b. Rights of Participants

Evanston

No concerns noted regarding MRSI's written policy on participant's rights..

Cheyenne

The Participant handbook had some rules and policies for MRSI as an overall agency that may not be appropriate for all participants at the Cheyenne branch.

c. Complaints/Grievances

A review of MRSI's complaint and grievance policy revealed that the agency's policy is missing key components required by the division. When reviewing actual case files concerning complaints filed by participants against the organization, follow up was not evident within acceptable time frames nor was resolution of the actual complaint.

d. Restraints

In an attempt to review MRSI's restraint policy, it was discovered that while MRSI does frequently use physical, chemical and manual restraints in their programs and facilities, no written policy governing the use of restraints could be produced as required by the Division. Written documentation, staff and participant interviews revealed that manual and chemical restraints occur frequently within the programs and do not follow or reflect the restraint standards as defined by Wyoming Medicaid rules. Additionally, during the site review it was documented that both sites are currently engaging in seclusion techniques and practices. Seclusion was observed at the Cheyenne site when one participant was put into a "quiet" room and a chair was placed in front of the entrance preventing the participant from exiting the room. Staff and participant interviews at the Evanston site revealed that participants are put into "quiet" rooms and are required to stay in the room until staff members permit the participants to

exit. Documentation was also produced verifying that participants are being involuntarily confined.

e. Positive Behavior Support Plan
An attempt to review MRSI's positive behavior support plan showed that the agency does not currently have this policy as required by the Division. It was also noted that the organization's behavior support plans, which have been approved by the Division, are not consistently meeting the required standards.

C. Staff Qualifications and Staff Training

a. Participant specific training

Evanston

To assess this area of the site review, surveyors reviewed five staff files. Upon assessment, 100% of the staff files reviewed contained appropriate documentation confirming that staff met the qualifications for the services they are providing. Every file contained results of background checks, current CPR and 1st aid certification.

Cheyenne

Six staff files were reviewed in Cheyenne. All of the files met the qualification of services and had the necessary requirements.

Agency Wide

Surveyors also reviewed staff files to assure the appropriate participant specific training had been provided by MRSI. Documentation of participant specific training was evident in every file however the training logs did not contain all required training categories to satisfy the training requirements as prescribed by Wyoming Medicaid Rules.

During the file review it was not evident that staff members were trained in incident reporting. Thirteen members of management and frontline staff were interviewed between both Evanston and Cheyenne sites and it was found that one of thirteen could fully articulate the Division's policy on incident reporting including specific categories and agencies requiring notification.

D. Emergency Drills and Inspections

Surveyors reviewed a sample of emergency drills and inspections for service locations in Evanston and Cheyenne.

Evanston

The Evanston site demonstrated that emergency drills are being conducted and concerns are identified when appropriate with follow up documentation available. The Evanston site's internal inspections are being conducted and follow up on concerns is evident. When reviewing external inspections, all locations proved that external inspections had been completed within the appropriate time frame.

A concern was found when reviewing the external inspection for the "Independence" house. An inspection dated 11/6/2006 states non-critical violations must be corrected within 60 days. The following violations were listed as non-critical with no follow up documented and was concurrently witnessed by survey staff during inspections:

- Badly damaged counter top in the kitchen

- Bath tub caulking is moldy

Cheyenne

The Cheyenne site had a variety of drills but did not include all recommended categories as required by CARF. Some of the homes were correctly identifying the agency drill for that month, but the staff would then conduct a different drill. Forms for day habilitation drills did not include times that drills were conducted and often were missing the date of the drill. The residential habilitation drills were all conducted in the evening after dinner. Drills are required to be conducted on all shifts and at a variety of times as set forth by CARF. Four of the drills appropriately had concerns identified or items requesting follow-up. Only one of the four drills displayed documented follow-up.

The Cheyenne site completed all required external inspections for three sites that were reviewed during the survey. Two of the three inspections required follow-up actions. Both displayed completed follow up with one inspection missing dated specifics of the completed follow-up. Internal inspections were completed at two of the residential homes. One of these inspections had required follow-up but did not have the documentation of its completion. The day habilitation and administration building did not have documentation of the required comprehensive self inspection.

E. Progress Made On DDD's Recommendations From the Previous Survey

It appeared that recommendations made during last year's site survey were progressing with exception to one. It states:

> It is recommended that MRSI continue to review objectives during team meetings and work with participant's team to develop more individual objectives for participants.

During the file reviews, survey staff found that this was not consistently occurring in the Individual Plans of Care.

F. Progress Made on CARF Recommendations From Previous CARF Survey

Out of 24 recommendations given by CARF in MRSI's most recent CARF report, survey staff followed up on two recommendations to monitor the progress made by MRSI. The first recommendation states:

> Homes owned by the organization do not appear to receive the same level of maintenance as the office buildings. The organization should ensure that all facilities controlled by the organization provide a healthy and safe environment.

Survey staff found little follow up on the specific concerns outlined in the 2006 CARF report and a recommendation pertaining to the lack of follow up is referenced in the residential section of this report.

The second recommendation states:

> When transportation services are provided for persons served, the organization should ensure safety features in vehicle(s), safety equipment, communication devices, road warning/hazard equipment and first aid supplies.

Survey staff found identical issues during the vehicle inspections and the lack of follow up is referenced in the vehicles section of this report.

G. Vehicles

Vehicles located at both Evanston and Cheyenne sites were inspected to assure that they are suitably maintained, contain adequate safety supplies, functioning safety features and have current insurance and registration information.

Evanston

Insurance was not evident in three vehicles that were inspected as required by CARF. This requirement would demonstrate compliance with federal, state, provincial, county and city requirements.

Four vehicles had missing or broken safety features including malfunctioning reverse lights, cracked windshields, unstable passenger seats, mal-functioning windows, door latches not catching and securing the door into place, horn/steering wheel broken and cracked tail lights.

Communication devices were not available to staff members driving the vehicles as required by CARF.

Poor maintenance of the inspected vehicles was evident with characteristics such as chipping paint, severely worn upholstery, denting in the left or right rear corners of the vehicle, rusting exterior, holes in internal walls, broken window shades and one vehicle took four tries to start.

Written emergency procedures were not available in any of the vehicles inspected as required by CARF.

None of the vehicles examined contained road warning or hazard equipment as required by CARF.

Participant emergency information is not consistently being utilized during transport as required by CARF.

Cheyenne

Participant emergency information is not consistently being utilized during transport as required by CARF.

Exemplary Practices:

- None

Commendations:

Cheyenne

- The Cheyenne site is commended for maintaining the philosophy of trying to reduce physical restraints as MRSI Cheyenne continues to find ways to implement such a philosophy into practice, such as the site's increased awareness of data tracking and analysis.

Suggestions:

Cheyenne

- It is suggested the Cheyenne site change the drill form to separate comments from concerns for required follow up.
- It is suggested the Cheyenne site update the participant handbook to reflect the individual practices of the Cheyenne branch that may differ from the Evanston branch.

- It is suggested the Cheyenne site add a fifth color for internal incident reports and add all the reportable categories.

Evanston

- It is suggested that fire extinguishers utilized in the vehicles have gauges or dates of last inspections.
- It is suggested that the quiet rooms be evaluated for comfort and have furnishings that make the rooms more comfortable without increasing the risk of injury due to disagreeable behaviors.

Recommendations:

It Is Recommended That MRSI Submit A Quality Improvement Plan by September 28, 2007 for the Following Areas Of Non-Compliance that Relate to Health, Safety, Welfare or Rights of Participants:

- The vehicles at the Evanston site are not meeting all safety and other transportation standards (CARF Section 1.E.9).
- For the second consecutive year the Evanston site is not assuring the group homes are providing a healthy and safe environment (CARF 2 E. 1 and Wyoming Medicaid rules, Chapter 45, Section 23).

It Is Recommended That MRSI Submit A Quality Improvement Plan by October 8, 2007 for the following areas of non-compliance:

Evanston

- The Evanston site has not completed required follow-up of non-critical violations cited on the 2006 external inspection report (CARF Section 1.E.11).

Cheyenne

- The Cheyenne site is not completing the required comprehensive self-inspections of the Day Habilitation/Administrative Building (CARF Section 1.E.12).
- The Cheyenne site is not documenting all pertinent information on their drill and inspection forms, including dates, times conducted, signatures and is not documenting when the follow up has been completed (CARF Section 1.E.4).

Agency Wide

- The organization is not consistently completing the required quarterly reviews of behavior support plans to determine their effectiveness and is not assuring community restrictions are time limited and include opportunities to reduce the length of time on restriction (Wyoming Medicaid rules Chapter 45, Section 29).
- The organization's participant specific training logs do not include all required components (Wyoming Medicaid rules Chapter 45 section 26).
- Staff within the organization are not able to articulate the Division's Notification of Incident Process (Wyoming Medicaid rules Chapter 45, section 30).
- The organization's incident reporting policy is missing components of the Division's incident reporting requirements (Wyoming Medicaid rules Chapter 45, Section 30).
- The organization has not developed and implemented a restraint policy (Wyoming Medicaid rules Chapter.45, Section 28).
- The organization's current complaint/grievance policy does not reflect all required components (CARF Section 1.D.3).
- The organization does not currently assure emergency information on participants is readily available during transport (CARF Section 1.E.5).

- The organization is not ensuring that seclusion is not occurring during waiver services (Wyoming Medicaid Chapter 45, Section 4).
- The organization's behavior support plans, which have been approved by the Division, are not consistently meeting the required standards and therefore the organization must work with the appropriate waiver staff to develop a plan to address this concern (Wyoming Medicaid rules Chapter 45, Section 29).

II. Results of Participant Specific Reviews

A total of ten participant files were reviewed during the survey between both Evanston and Cheyenne sites.

Evanston

A. Results of review of random sample

A. Implementation of IPC Findings

Participant #1

Universal objectives implemented by the team were stated with a measurable percentage but this was not followed through on to the schedules. The objectives are duplicated from day habilitation to residential habilitation and are related to behaviors and staff interventions.

Emergency information included current medications, emergency contact, and allergies. A concern is that Participant #1 has medication changes and that this information is updated and kept current on the emergency information sheet.

Schedules were reviewed and documentation indicated that the schedules are being followed but that they are not measurable with use of (+) and (-).

Activities and community outings occur for this participant but are limited due to his behaviors and the frequency of being on restriction. Restrictions can be restarted with any behavior or refusal to attend a psychology appointment. All of his belongings, including his Bible at times, have been taken away as noted in internal incident reports and the internal communication log. Participant #1 has had several incidents of having "face down" floor restraints.

Participant #2

Universal objectives implemented by the team were stated with a measurable percentage but this was not followed through on to the schedules. The objectives are duplicated from day habilitation to residential habilitation and are related to behaviors and staff interventions.

Emergency information included current medications, emergency contact, and allergies. A concern is that Participant #2 has multiple medication changes and that this information is updated and kept current on the emergency information sheet.

Schedules were reviewed and documentation indicated that the schedules are being followed but that they are not measurable with use of (+) and (-).

Activities and community outings rarely occur for Participant #2 due to his behaviors and the frequency of being on restriction which can total to an amount of 144 hours and can be restarted with any behavior or refusal to attend a psychology appointment. It was stated by a direct care staff that he is not allowed to look into the kitchen or to talk about food as he perseverates on the topic and can then become agitated and have behaviors. This information is not contained within his IPC. It was also stated that if

Participant #2 tries to enter the kitchen he is "taken down" into a Mandt hold. Staff also stated that there is to be one staff at the entrance to the kitchen at all times to prevent Participant #2 from entering the kitchen as he will eat whatever he can find, even food found in the trash. The refrigerator, freezer, and cabinets are locked because of this. Participant #2 eats alone due to his tendency to steal food off of other participants' plates or drink their fluids.
It was documented on an incident report that Participant #2 was having difficulty breathing during one of the restraints being administered.

Participant #3
Emergency information was present and complete.
Objectives and schedules were reviewed. Due to the broad residential habilitation training goal, many activities may be included. During the first two months of this service, 12 of 19 training sessions were going out to eat. Through the next two months, the training sessions reflected more of a training opportunity. The Case manager reported that the Waiver Specialist has worked with him to develop appropriate residential habilitation training goals.

Participant #4
One release, for Evanston Regional Hospital, did not have a time limit nor did it include what specific information it covered.
Emergency information was present, and was very thorough and complete.
Case Management documentation was reviewed, and the documentation indicated that the minimum requirements of monthly contact and annual meetings and reviews were met. The narrative regarding monthly contact and summary of progress was very generic and repetitive. The documentation did not include any reference to the participant's progress on goals and objectives, behavior plan, or incident reports. In speaking with the case manager, it appeared that he was more knowledgeable about the participant's progress than the documentation indicates. He reported that he monitors the plan through the home visit, completing 60 minutes of contact per month, In addition, the May 2007 home visit was documented as being two minutes in duration and none of the home visits were of significant length.
Objectives and schedules were reviewed. Both of the participant's objectives, residential and pre-vocational, were repeated from the 2006 plan to the current plan, although the documentation reflected that she had met the goals in 2006.
The case manger reported a number of reasons for the repetition. He states that the participant's behavioral issues outweigh the importance of these goals, explaining that she is "devious" and he is waiting on "marked changes in her behavior to be able to plan other goals and objectives." He continued that since her stealing is a barrier to employment, given her past history of stealing at jobs, it seems like pre-vocational is the "wrong placement" for her, rather than day habilitation. He also added that he relies on supervisors and staff at the service locations, he asks the participant for input about her goals, and he "looks for goals and objectives that the state will approve."
The schedules referred to what the participant "refrained from" with no reference to positive replacement behaviors. In general, the goals and documentation lacked the element of training, focusing more on the tracking of whether or not negative behaviors occurred.

When the participant was interviewed at her home, she was unable to articulate her goals, although she recognized them when stated to her. She was able to report her behavioral goals. When she and her residential support staff were asked whether or not she participates in group activities in the house, the staff reported that she actively participates and the participant stated that she enjoys "doing things" at the house. The participant was observed in her home and at the day habilitation site. In both settings she appeared calm, but apprehensive about the survey staff. She seemed to be able to choose to move around throughout both settings as long as staff could observe her. At the group home, she and a staff member were working on a puzzle book together, and at the day habilitation site, she selected and then worked on an activity away the rest of the group. She was also observed wearing her gloves at the day habilitation site.

Participant #5

Emergency information was present, the only information that was missing is an emergency contact, and the assumption is because the participant is her own guardian with no known family.

Nursing notes were also reviewed, they were complete, however, it was noted that nursing only completed five minutes of care each time they visited the participant, whether they were just giving medication, or doing a full body assessment and other nursing duties.

The participant's positive behavioral support plan was reviewed and it does not meet the Division's requirements, including maintaining dignity, respect, values, identification of replacement behaviors or approaches that assist the participant in getting needs met in appropriate ways, be reviewed quarterly to assess effectiveness. For the restriction aspect of the plan it does not show how the right(s) will be restored, information on temporarily lifting restriction during times of personal crisis, will not exceed 36 hours unless there are written guidelines from a psychologist. For the 24 hour restriction it does not include information on how to reduce the length of the restriction.

Case Management documentation was reviewed and met Division requirements, however, it was noted that home visits in the past three months were five minutes each. Objectives and schedules were reviewed, the objectives were vague and there was no way of measuring progress on the objectives. Objectives were measured by using (+) and (-) that measured frequency of how often the goal was addressed. Schedules were negatively written and punitive.

B. Billing and Documentation Findings:

Participant #1

During review of billing for Day Habilitation there were no concerns noted. It was also noted that there were two direct care staff documenting on the same document with the same initials.

Participant #2

During review of billing for nursing services there were no concerns noted. During the review of documentation it was noted that nursing consistently documented five minutes for all participant contact regardless of nursing services being provided. It was also noted that there were two direct care staff documenting on the same document with

the same initials. The handwriting is similar so there is difficulty identifying who was doing the documentation without looking at schedules.

Participant #3
Case Management billing matched the documentation. No concerns noted.

Participant #4
Case Management billing matched the documentation. In April of 2007, the documentation supported 22 units of residential habilitation, while 25 units were billed. Documentation for the six month period also indicated the number of times the participant accessed the community as follows:

- January 2007 =8
- February 2007 =12
- March 2007 =7
- April 2007 =4
- May 2007 =7
- June 2007 =27

The participant's mother has been in Evanston in June and takes her out regularly, according to both the guardian and the case manager.

Participant #5
Residential Habilitation Documentation was reviewed for a six month period and no concerns were noted.

C. Guardian or Family Follow-up Findings:

Participant #1
The guardian listed for this participant does not have a phone and consequently creates concerns on the frequency of notification of medication changes, when restraints are used, and in case of an emergency.

Participant #2
The guardian reports that she is "okay" with the services that are provided at MRSI. She reports being contacted when medications are changed but not when restraints are used.

Participant #3
The guardian interviewed reported that services through MRSI are "going fine" for her daughter. She reported that the case manager visits the participant and guardian in their home monthly, and he is available and accessible throughout the month if the guardian contacts him. The guardian said that she is "seeing progress" in her daughter through this training and the guardian reported no concerns.

Participant #4
The guardian interviewed reported that Participant #4 is doing "very well" and is "calmer" since receiving services at MRSI. She added that the participant has "improved her abilities to relate and has acclimated well". She stated that the majority of staff who work with her daughter are "kind and compassionate." She reported that

she is invited to participate in the twice annual plan of care meetings, which she participates in via phone from Florida. The guardian expressed that she has requested a team meeting during the months of her annual visit to Evanston, and the staff response was that the time of the guardian visit is not during the participant's scheduled time.
The guardian also stated that she was unaware of the exact caloric amount of her daughter's diet, but she knew that it was being restricted so that her daughter would lose weight. She stated that the weight loss has been a "god send."
The guardian also reported that she feels that the community restrictions seem "excessive" related to her daughter's skin picking. The dermatologist said that the participant's skin picking behavior is "no worse than mine [dermatologist]".
The guardian stated that the participant's psychologist, "tolerates me" but "does not listen to me." "He's not willing" to hear her input. The guardian also stated that the restrictions related to not talking to other people and not carrying her own possessions are "too much restriction".
The guardian explained that there recently was a housing reorganization related to "staffing issues." She said she was very glad that the staff visited with the participant ahead of time and told her that the move would be her decision. The guardian added that neither she nor her daughter met any of the staff or participated in any kind of transition prior to the move date, which was "very difficult for her and for the families."

Participant #5
The participant is her own guardian, and she was interviewed in employment and residential habilitation service areas. She seemed satisfied with services and supports, and only noted that she would like to live somewhere less busy and quieter. After interviewing the case manager it is apparent that the team is working to find a better placement for the participant.

D. Incident Report Follow-up Findings

Participant #1
Internal incidents were numerous relating to the amount of physical and chemical restraints secondary to participant behaviors. They were routed to the psychologist for review and follow up was documented. The case manager's initials were also noted on the incident reports for review. Nursing reports that they only receive the incident reports if it relates to an as needed medication being given.

Participant #2
Same findings as Participant #1.

Participant #3
There were no incident reports for the six month period that was reviewed. This was verified by the case manager, who confirmed that the team members know when and how to complete a report.

Participant #4
No critical incident reports were filed in the six month period that was reviewed, and the incident report review did not indicate that any should have been filed. There were some trends of concern found on the agency's internal incidents that were reviewed.

- Many times an antecedent was left off of the report.
- The communication on the incident reports between direct care staff and the psychologist indicated inconsistency regarding whether or not the participant could earn time off of an implemented community restriction. When the case manager was interviewed, he stated that he was unsure about whether or not the plan included a way for her to earn time off of restriction. The ability to earn time off is a requirement of the DDD's Rules regarding positive behavioral support plans.
- The staff wrote some incident reports about "sneaky" behavior, resulting in community restrictions. When other staff wrote notes to the psychologist that "sneaky behavior" was not listed in the behavior plan, the psychologist's response was that a new behavior plan was being developed. The case manager signed but did not list a comment on these reports.
- Another incident report included a staff statement that "I made her bathe" in response to the participant picking her skin on 5/27/07. The staff explained that she thought that the picking behavior might be related to needing a bath. No comments were listed from the ISC, and the psychologist directed the staff to continue to follow the plan.

Participant #5

Incident reports were reviewed, were found to be complete and follow-up was noted. There were several trends identified and surrounded staff not allowing Participant #5 to have something because the staff incorrectly believed this was not written into her IPC. Staff were incorrect in this assumption which caused the participant to become upset. The other major trend noted was the fact that the participant would oversleep or miss snack time by a few minutes and when she asked staff if she could have her snack they would not allow her to. This made the participant very upset which caused verbal and physical aggression in many circumstances, which led the participant to be put on restriction.

E. Health or Safety Concerns with Participant:

Participant #1

During the file review it was noted that Participant #1 is on a fluid restriction but there are no physician's orders for this. It is documented on a consistent basis the amount of fluids that he has had for each shift. There was a physician order found that was dated 5/29/2007 that instructed staff to encourage fluids. No follow up or communication was noted in the communication log or in the participant's file. During the review of documentation it was noted that nursing consistently documented five minutes for all participant contact regardless of nursing services being provided.
Surveyors identified health concerns which include
Participant #1's fluid restriction in lieu of the order to encourage fluids, how amount of time is being tracked for restrictions, and that it is possible for him to have most of his personal belongings taken away for behavioral episodes including his Bible.

Participant #2

Participant #2 was observed at his residence during mealtime. He was seated in a small chair with a small desk type table looking out the window of the main living area, with

a piece of board separating him from the main dining area. At the time of observation, there were no other participants in the home and Participant #2 was not given the choice to sit at the main table. During the file review it was noted that he had abnormal laboratory results specifically his ammonia level and his lipase level. The reports stated that the physician was notified but no further follow up was in the file.
Surveyors identified health concerns which include the manner in which he is isolated at meal times, his fluid restriction in light of his abnormal lab results, his caloric intake, the amount of time he is on restrictions, the inability to access the community, and that it is possible for him to have all of his personal belongings taken away for behavioral purposes.

Participant #3
No health and safety concerns were noted.

Participant #4
The participant's behavior plan indicates the use of a video monitoring camera, related to her stealing behavior, that should be placed in the hallway of the group home. The case manager stated that he did not think that any other participants in the house had the camera listed in their plans as a rights restriction, and he stated that he would follow up and that the camera should be in the hall. The participant's plan of care says that the camera is to be used during hours of sleep, and it does not indicate where the camera is to be placed, and under home supervision in the plan, the camera is referred to as being "in my bedroom."
The ISC manager confirmed that MRSI participants generally have their daily food intake restricted to 1800 calories per day. Neither Participant #4's plan of care nor her behavior plan indicates dietary restrictions, and the nursing page that is signed by a physician does not indicate restricting the number of calories that this participant may have. The participant's plan also did not include any kind of dietary assessment.

Participant #5
No health and safety concerns were noted.

Exemplary Practices:

- None

Commendations:

- None

Suggestions:

- It is suggested that the team continues to work with waiver specialist to ensure that goals and objectives meet the service definition, including having measurable goals and task analyses for training (Participant #3).
- It is suggested that the ISC monitors the plan and services closely enough to provide feedback about whether or not training activities meet the service definition (Participant #3).
- It is suggested that MRSI obtain a dietary assessment so that the team can make more informed decisions and/or requests of the physician regarding the participant's nutritional needs (Participant #4).

- It is suggested that the team review all areas of the plan that mention the camera and ensure that the camera's use matches the written plan (Participant #4 and all participants residing in the home).

Recommendations:

- Documentation will be referred to Medicaid for review based on the residential habilitation services that were over billed from April 2007 (Chapter 45 Section 27) (Participant #4).
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Cheyenne

A. Implementation of IPC Findings

Participant #6

The instructions for night checks require physically checking the participant every 15 minutes during the night shift. This is invasive, disruptive to sleep, does not respect his dignity, and is not being documented by staff. There were some discrepancies between the psychological evaluation and the instructions of the IPC. The behavior support plan leaves an open ended restriction that must be fixed in compliance with Medicaid rules. The meal tracking does not reflect the IPC directives of double portions. There is no tracking of bathing frequency as required by the IPC. The participant is going to bed almost immediately upon returning home, which results in the participant staying in bed for 14-16 hours a day. Staff are not tracking his choice of the YMCA or AA as indicated in the IPC. These choices of community integration were removed from his schedule. The participant did not respond to an attempted interview.

Participant #7

The plan of care for Participant #7 was person centered and reflected his personal preferences. The 'About Me' section of his plan of care respectfully captured some very important family issues for. Interviews revealed this participant is on an 1800 calorie diet and he said he liked to eat and did not like this diet. The IPC noted Participant #7 is "to be encouraged to follow a low fat diet", but did not specify dietary restrictions. The tracking of objective progress is limited to Participant #10's compliance in performing the objective, and does not include tracking of specific skill progress.

Participant #8

Based on review of documentation, service observation, and interviews, it appears that the IPC for Participant #8 is being implemented as written and planned. Participant #8 reported enjoying where she lives and who she lives with however does not like how she spends her time. She reports being unable to have community integration due to inadequate staffing levels while other participants are on restriction.

Participant #9

Based on review of documentation, service observation, and interviews, it appears that the IPC for Participant #9 is being implemented as written and planned. Participant #9 was observed in both his day habilitation and residential habilitation environments and appeared to be comfortable in both service areas. It was noted that the supervision and support of the IPC was highly contradictory and was indiscernible in regards to his actual needs.

Participant #10

Surveyors were able to do a partial review, including reviewing daily schedules and the behavior support plan for Participant #10. Staff interviews and review of the behavior support plan revealed that the use of physical restraint was mentioned as an intervention when Participant #10 was escalating and a possible danger to himself or others. An interview with Participant #10 and another staff showed that physical restraint is not to be used and law enforcement is to be called to assist with de-escalation if needed.

B. Billing and Documentation Findings:

Participant #6

Residential habilitation and day habilitation billing and documentation were reviewed for a six month period and no concerns were noted. At the end of the plan year, MRSI ran out of one unit for day habilitation and the service was provided anyway.

Participant #7

Residential habilitation and day habilitation billing and documentation were reviewed for a six month period and no concerns were noted.

Participant #8

Upon review of the documentation of services and billing records, it was noted that, on occasion, certain Skilled Nursing services were being delivered and billed that were not listed on the physician's order form.

Participant #9

Upon review of the documentation of services and billing records for dietary services, it was noted that all billing was accurate and descriptive of the services received.

Participant #10

The partial review did not include a review of billing.

C. Guardian or Family Follow-up Findings:

Participant #6

The guardian interviewed was happy with services provided by MRSI and had no concerns.

Participant #7

Surveyors were unable to contact the guardian

Participant #8

Participant #8's guardian was interviewed and reported that in general she was happy with services. She did express concerns that some of the staff in the residential habilitation staff were under trained. She had concerns for the monitoring of her daughter. Participant #8's mother further stated that she thought her daughter received "good" medical care along with "excellent" psychological and psychiatric services.

Participant #9

Participant #9's guardian was interviewed and reported that, overall, he was happy with services. He did express concerns that he was not being informed when

physical restraints were employed.

Participant #10
The partial review did not include a guardian interview.

D. Incident Report Follow-up Findings:

Participant #6
One critical incident report concerned the 15 minute bed checks by staff. Participant #10 has apparent random agitations that result in him punching the wall and re-injuring his hand. The provider should continue to help the participant to avoid self-injurious behavior

Participant #7
All incident reports reviewed for Participant #7 were complete and noted follow-up when appropriate.

Participant #8
Multiple incident reports were filed concerning Participant #8's behavior. Few of these reports indicated follow-up with the identified concerns.

Participant #9
Many incident reports concerning Participant #9's behavior were filed. Few reports indicated follow-up had been completed.

Participant #10
The partial review did not include a review of specific incidents.

E. Health or Safety Concerns with Participant:

Participant #6
The participant is identified as having depression but is living the majority of his day in a dark, isolated basement. He is staying in bed for 14 hours a day, with no activity, no interaction – potentially exacerbating a depression cycle.

Participant #7
No health and safety concerns were identified.

Participant #8
Participant #8 was on an 1800 calorie per day diet in which the IPC made no mention. Participant #8 did mention that she would like to have a wider variety of food at mealtimes.

Participant #9
Participant Four was on an 1800 calorie per day diet in which the IPC made no mention of this dietary restriction.

Participant #10

There was a restraint usage identified that showed inconsistencies between staff interviews and the behavior support plan.

Exemplary Practices:

- None

Commendations:

- None

Suggestions:

Cheyenne

- It is suggested the Cheyenne site add medications to the participant's emergency face sheet.

Recommendations:

It Is Recommended That MRSI Submit A Quality Improvement Plan by October 8, 2007 for the Following Areas Of Non-Compliance:

Cheyenne

- Discrepancies were identified between the individual plan of care and it's implementation for:
  - Participant #6 psychological, supports, daily schedules, food and night check tracking had an aspect that was contradicted within the IPC.
  - Participant #7, #8 and #9 are on diets but this is not reflected in the participants' plans of care nor were there physician orders for the diet.
  - Participant #9 the supports outlined in the plan of care, including required supervision levels, are contradictory and therefore staff are unable to follow the plan.
  - Participant #10 the participant's behavior support plan is in conflict with what staff reported when interviewed and with what the participant articulated when interviewed.

Agency Wide

- At both MRSI sites, guardians of two participants stated they are not consistently being notified of restraint usage (Wyoming Medicaid rules Chapter 45, Section 28).
- Many schedules submitted by the organization and approved by the Division currently focus on tracking negative behaviors and restrictions and do not focus on community integration and preferred daily activities. The organization must work with the appropriate waiver staff to develop a plan to address this concern (Wyoming Medicaid rules Chapters 41, 42 and 43, Section 9).
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III. Review of Services

A. Residential habilitation services

Surveyors visited five residential homes in both locations in Evanston and Cheyenne to interview participants and staff, inspect the physical site and observe service delivery.

Evanston

a. Service observation

All homes were minimally decorated. Participants did not have a choice in meals or mealtime planning with the exception of Sundays. Participants had no input or choice in what chores to complete in their home with the exception of Sundays. In the "Citation" home it was observed that one staff physically redirected a participant without using other interventions first.

b. Random interviews with participants

Staff stated that it is MRSI's policy that participants can eat between the hours of 8:30am and 8:30pm and at all regularly scheduled meals or snacks. If participants miss snack time they cannot have the snack later even if they request it. It was also reported by staff that if participants do not eat dinner or at least 50% of their meal they cannot have a snack.

According to participants and staff, outings in residential habilitation occur between two to four times per month and outings only occur to go to dinner or Wal-Mart. One participant stated that they cannot go on more outings because of the cost of gas.

Menus are set by the organization and are the same for every house. Staff and participants stated that they cannot deviate from the menus, because as one staff announced, "participants need a structured environment and if everyone had what they wanted it would be chaotic." In addition, it was reported by a case manager that "MRSI will not be responsible for fixing multiple meals".

All staff interviewed in the residential setting were unaware of the Division's notice of incident reporting process. Staff in residential habilitation also stated that they, "would only call 911 in case of a fire, and anyone who cannot be calmed down MANDT is used on them."

c. Walk-through of homes

The following observations were noted during residential inspections:

Alpine house

Backdoor was hard to open.
Open crawl space was witnessed with a 5'-6' drop.
Cigarette containers in the front and back of the residence were full.

High Ridge house

Downstairs patio door does not lock.
Downstairs bathroom is missing tile around the shower and mold was present.
Chemicals were locked up with exception to shampoos, conditioners, and laundry soap.

Independence house

Garage was full and cluttered with boxes and participants' personal items.
Freezer in garage was unlocked.
Carpet was stained and worn.
Front door was wide open and screen door had no screen.
There was an open ceiling in downstairs bathroom.
Couches were in poor condition and sagging.
Window on front of house was broken.
Upstairs bedroom had urine odor.
Shower stall downstairs was rusted with patched drywall.
Participant bedroom had no screen on window.
Downstairs bathroom toilet was leaking.
Sunscreen and steam cleaner is in an open closet.
Curtains are falling down.
Wood cabinets in kitchen were splintering.
Dining table was old and pictures were scribbled on the tabletop in permanent marker.
Kitchen counter was badly damaged.

Apache house

Cigarette bucket outside was full.

Participant's stated they did not have a choice in the house decorations.
Stained carpet was evident in the residence.
Locked refrigerator and freezer were present in the kitchen. This restriction was not written in all plans of care for all participants residing in the home however all participants were restricted from use.
Side door had a broken latch, screen was popped out, and the latch release button had a long piece of sharp metal sticking out.
Back door has an alarm that is set for a participant no longer residing in the home. This restriction was not written in all plans of care for all participants residing in the home.
Video monitor camera was present in the hallway. This restriction was not written in all plans of care for all participants residing in the home.

Citation

Home was decorated and no health and safety concerns were noted however the home appeared dirty.

Cheyenne

a. Service Observation

Staff appeared to be providing caring and appropriate services in the homes. Staff had a good knowledge base for the participants they were serving, including medical, behavioral, and restrictions. The standard interaction between staff and participants appeared genuine and caring. Staff knew many of the informal likes and dislikes of participants. Roommates were interacting appropriately.

b. Random interviews with participants

Participants expressed overall satisfaction with their homes. Some expressed dislike for the heat in the homes, which surveyors also observed to be stifling in some rooms. Some participants also expressed a desire for more community integration and activities.

c. Walk-through of homes

The "Taft" home did not have the required carbon monoxide detector, had a non-functioning shower in the basement, and was very hot upstairs. One participant in the "Taft" home requested fresh air in his room which was significantly hotter than an already hot living room. Many of the homes were hot with minimal fresh air flow. The walk-through inspection of the residential sites revealed inconsistencies between the posting of "no smoking" signs and cigarette disposal containers placed below these signs. Additionally, surveyors observed people smoking in garages near propane tanks. People were also found to be smoking outside the external door while the door was open allowing smoke to enter the home. Most of the bedrooms were decorated according to taste and preference. There were two bedrooms identified that participants and staff have not taken the time to personalize.
In many of the homes there was a stark contrast in décor between the upper level and the basement.

Exemplary Practices:

- None

Commendations:

- None

Suggestions:

- None

Recommendations:

It Is Recommended That MRSI Submit A Quality Improvement Plan by October 8, 2007 for the Following Areas Of Non-Compliance:

Evanston

- Participants' rights at the Evanston Apache group home are being restricted by the use of the door alarm and video monitor. These restrictions are not listed in the participants' plans of care (Wyoming Medicaid Rules Chapter 41 and 42, Section 9).
- Staff at the Evanston site are not using the lowest level of intervention first, such as verbal communication, before physically redirecting participants (Chapter 45, Section 28).

Cheyenne

- At the time of the survey, the upstairs of the Cheyenne group homes were hot with little, fresh air flow, which could negatively impact the health of participants (CARF 2.E.1).
- The Cheyenne site exhibited deficiencies and ineffective communication between the Day Habilitation/Administration site and the residential sites resulting in staff not being informed of important information, including recommendations by professional staff, incident report tracking, behavior support updates and other daily information that is crucial for direct care.
- The Cheyenne site is not ensuring that their smoking policy and practice are protecting the health and safety of participants in all settings (CARF Section 2.E.1).

Agency Wide

- The organization is restricting participants individualized choices regarding community integration, daily activities, chores, mealtimes, menu planning, snack choice and times without including these restrictions in the participants' plans of care (CARF Section 2.A, 2.F, Section 4.J.2.and 4.E.2).
- The organization is not consistently providing participants with a community living setting that is personalized specifically the lack of appropriate furniture and personal décor (CARF 4.j.2.d).

B. Day habilitation/employment services

Surveyors were able to observe and interview participants at the Day Habilitation sites in Cheyenne and Evanston as well as observe the physical properties.

Evanston

a. Service observation

MRSI has six day habilitation groups that divide the participants based on participant ages, employment status, social and overall capabilities. Interaction between staff and participants was minimal. It was observed in Groups 3 and 6 that for 20-30 minutes staff were sitting at one table and participants at another table across the room with no interaction. It was also observed in Group 1 that the two participants that were the least able to initiate any type of interaction, had no staff interaction for 20 minutes. In Group 5 a surveyor was present for 40 minutes and it was noted that physical redirection was used in three instances without less invasive interactions being tried first. A participant was observed playing a board game with a staff member and interaction was appropriate.

Choices were offered to one participant about when exercises would be done. Staff stated that from the time participants arrived at the center until around 10:00 am, participants play games and engage in free time. After 10:00 am the psychological appointments start and the rest of the day is based around the psychological and nursing appointments. Dry erase boards were noticed in each of the group rooms which identified each participant's times for psychology, nursing, and wellness appointments as well as exercise and "seniors" which pertained to elder participants scheduled to go to the senior citizens center for lunch.
Schedules are not goal oriented, measurable, or specific to the participants. Goals or objectives have a propensity to be the same for both day habilitation and residential habilitation services. When interviewed, MRSI staff members described participant's goals as "she cleans off her area of the table" for 4 of the 6 participants in Group 1.
There are no programs done in the afternoons per direct care staff and participants.
Objectives and goals are being charted with (+) or (-) and are generally related to behaviors and not task related.
Outings are minimal among participants and occur only when the participants are not on community restrictions and only if the agency has provided adequate staffing.
Four participants were observed during supportive employment services. All appeared comfortable and content with their employment.
Direct care staff members were interviewed about the services that they provide while in the day habilitation service setting. An employee stated that there are "quiet" rooms that are used for participants who are "uncooperative". He reports that he has observed staff that will not let participants out of the "quiet" room even if the participant is calm and stating that they are ready to come out. He states from his observations that the staff will inform the participant of the amount of time remaining before the participant is allowed to leave the quiet room.

b. Random interviews with participants
During day habilitation services, a total of six participants were interviewed in Groups 1, 2, 3, and 6 about their schedule on a day to day basis. One response was that lunch was eaten at 12:00 then "nothing else" for the afternoon. Staff did not offer any additional information. When a participant was asked in Group 2 about his goals for day habilitation services, he stated that he "earns eat outs if he stays off of restrictions", works on art, and works on "smokes". He also stated that he is able to go out at least 1 time a week.
In Group 1 it was stated by a participant that he didn't feel well that day. On further questioning of why he wasn't feeling well, he stated, "they won't let me work". Staff stated that he does sit in a chair to shred and is also staffed 1:1 during work time.
Interviews with participants who were receiving supported employment were happy with their jobs, knew who to contact at the specific places of employment with concerns, and were comfortable with the tasks that they were performing. One participant stated that she would like to work 2 hours a day instead of 1 ½ hours but that her "doctor" (psychologist), would not approve this. When asked why, she stated because her psychologist thought that she may not be able to handle it because of the increased stress due to frequent changes in staff at her home.

c. Walk-through of day habilitation settings

The group rooms were generally cluttered with furniture and tables, giving an uninviting appearance to the rooms.
Environmental inspection of the facility revealed the following concerns or violations:

- Address is not present on the building.
- In PARC (computer) room there is a large painting propped on a table with a sharp wire extending outwards.
- Kitchen doors have signs stating that the doors are to be kept locked at all times. The door was found unlocked once with no one in the kitchen and both doors are propped open.
- The shredder in the kitchen has no safety device on it to prevent injuries from insertion of fingers into the shredding device.
- In the psychology hallway, there is a sign posted stating that there are to be no chairs in the hallway. There were two chairs present at the time of observation.
- In the accounting hallway there is a black plastic in front of an emergency exit door and is a tripping hazard. The area was also in need of being cleaned.
- In Group 1 the snack closet was unlocked and accessible to staff and participants.
- Outside Group 1 a custodial closet was open and unsupervised.
- In the exercise room there is a broken seat on one of the chairs.
- There is no evidence of a Carbon Monoxide detector in the facility.

Cheyenne

a. Service observation

Surveyors observed activities that the participants appeared to enjoy. Surveyors observed many positive interactions between participants and day habilitation staff. Many participants were working on their objectives or day habilitation curriculum. Participant's daily schedules were reviewed. They included tracking of participation in their IPC objective(s), medical/psychological appointments, and tracking of behavior support data. Many schedules were lacking individualized preferences related to activities, community integration, other training opportunities, and measurable training objectives. During interviews with participants and staff at the day habilitation site it was reported that the agency has formed a "day habilitation enhancement committee" headed by various participants and staff at MRSI. A new day habilitation curriculum has been developed which includes adult education, music, arts and community integration. Participants expressed excitement about getting to move into different rooms to engage in various types of activities and training opportunities.
Day habilitation for participants with ABI is appropriately separated and given personal space. All service observations appeared caring, knowledgeable, and with appropriate staff support and interaction. It was again noted that participants' schedules were being driven by medical and psychological appointments and were not as focused on community integration, employment, or activities reflecting participant choice and input.

b. Random Interviews with participants

Many of the participants interviewed expressed satisfaction with their day services. Some participants interviewed expressed concern with their day habilitation services in

which they stated they wanted to go into the community more frequently, wanted more stimulating activities, and many participants expressed a desire to work and earn wages.

c. Walk through of day habilitation

At the Cheyenne Day Habilitation center there was no carbon monoxide detector installed. Additionally, staff and participants were smoking in front of the building with the doors propped open which allowed smoke to enter the building.

Exemplary Practices:

- None

Commendations:

- The Cheyenne site is to be commended for the development of a "day habilitation enhancement committee" involving participant driven changes to improve the overall satisfaction with day activities.

Suggestions:

- It is suggested the Cheyenne site assess current prevocational and supported employment opportunities to look at expanding prevocational training and employment options for participants at MRSI. This would include addressing these issues in each participant's plan of care identifying supports needed, barriers to employment, and how the team can help support the person to achieve their vocational goals.

Recommendations:

It Is Recommended That MRSI Submit A Quality Improvement Plan by October 8, 2007 for the Following Areas Of Non-Compliance:

Evanston

- The Evanston site has the following concerns that could negatively impact the health and safety of participants (CARF Section 2.E.1. & Wyoming Medicaid Rules, Chapter 45, Section 23):
  - Shredder without a hand guard
  - Address not posted on building
  - Large. Painting propped on a table with sharp wire extending outwards
  - Kitchen doors have signs stating doors are to be kept locked at all times. Doors were found to be unlocked and propped open
  - Sign posted in psychology hallway states "No chairs in hallway" and two chairs were present.
  - In accounting hallway black plastic was found in front of emergency exit door presenting a tripping hazard
  - Group room 1 snack closet was unlocked and accessible to clients and staff
  - Custodial closet found to be open and unsupervised
  - Broken seat found in exercise room

Cheyenne

- The organization does not have carbon monoxide detectors installed in all services areas that have a source of natural gas (Wyoming Medicaid rules Chapter 45, Section 23).
-

C. Other Services

Surveyors observed and interviewed nursing services at both the Evanston and Cheyenne Sites.

Evanston

a. Service observation

The delivery of skilled nursing was observed and the following concerns were noted:

- Physical and behavioral assessments, vital signs and weight measurements, medication administration and management, and skin integrity assessment had been ordered to be done daily with no evidence that this is being done on a daily basis.
- Medication administration is being performed by direct care staff when ordered for nursing to do this.
- Medication changes are not being followed up on for efficacy or side effects, nor are abnormal laboratory results.

b. Random interviews with participants/guardians
No interviews were conducted during this survey.

c. Walk-through of service settings
The physical area for skilled nursing services was appropriate for the delivery of services in which dignity and confidentiality could be maintained.

d. Staff Interviews
Concerns were identified as nurses appeared to be providing services that were beyond the scope of practice defined by the Wyoming Nursing Practice Act. These concerns included medication packaging and the dispensing of medications for non-medical staff to administer. Additional concerns showed nursing staff were instituting fluid and calorie restrictions independent of physician's orders, imposing activity restrictions on participants independent of physician's orders and the delegation of existing physician's orders to non-medical staff.

Cheyenne

a. Service Observation
The delivery of Skilled Nursing services was observed on two occasions and was noted to be appropriate in delivery in regards to accepted standards of care.

b. Random interviews with participants/guardians
During the survey, guardian satisfaction of Skilled Nursing services was expressed.

c. Walk-through of service settings
The physical area for skilled nursing services was appropriate for the delivery of services in which dignity and confidentiality could be maintained.

d. Staff Interviews
The nursing staff demonstrated appropriate knowledge of participant's medical, physical, and emotional needs. Concerns were identified as the nurses appeared to be providing services that were beyond the scope of practice defined by the Wyoming Nursing Practice Act. These concerns included instituting fluid and calorie restrictions independent of physician's orders and the delegation of physician's orders to non-medical staff.

Exemplary Practices:

- None

Commendations:

- None

Suggestions:

- None

Recommendations:

It Is Recommended That MRSI Submit A Quality Improvement Plan by September 28, 2007 for the Following Areas Of Non-Compliance that Relate to Health, Safety, Welfare or Rights of Participants:

- The organization is not consistently following physician's orders for skilled nursing (Medicaid Waiver rules Chapters. 41, 42 and 43, Section 7).
- The organization is restricting participants' rights to food choice, fluid intake and diet (caloric restriction) without including these restrictions in the individual plan of care and without being prescribed by a medical doctor (Wyoming Medicaid rules Chapters 41, 42 and 43, Section 9).

D. Case Management Services (ISC)

Evanston

MRSI case management documentation included monthly/quarterly notes and home visits. Documentation was generic and repetitive across all monthly notes of the files reviewed. One out of four case managers could produce evidence of the method used to track individual concerns. In general, case managers reported that other members of the team and/or staff completed some aspects of the case management services.

The case managers indicated more interaction with participants and knowledge of participant specific information during interviews compared to what was reflected in their case management notes. Progress on individual goals and objectives was not included in the monthly documentation of the files reviewed, and for the goals that appeared to have been met, no changes were recommended or implemented.

Incident Reports included ISC signature, but no recommendations for change or clarification for staff. One case manager stated having confidence to "advocate for the participant and speak to rights if the psychologists are off base." Documentation of home visits exhibited a trend in the visits being 5 minutes in length or less.

Team meeting minutes were included in the files and documentation and communication of plan changes through "green sheets" were evident in participant files. Most of this type of change or communication appeared to be driven by the psychology and/or nursing staff.

When asked, none of the case managers could accurately report the current requirements for Positive Behavior Support Plans or Restraint policies.

Cheyenne

Surveyors interviewed case managers, participants and guardians on satisfaction with case management services. Participants and guardians interviewed expressed satisfaction with the case management services provided by MRSI. It was apparent the case managers had working knowledge of the participants on their caseloads.

Surveyors reviewed case management monthly/quarterly notes, team meeting minutes, ISC follow-up on plan monitoring and incident reporting. Case Managers articulated and documented using the team process to address concerns, incidents, etc. Case managers have contact scheduled regularly with many participants on their caseloads and participants appear very comfortable visiting with their case managers when concerns arise. Case managers were knowledgeable of rights restrictions, behavior support plans, and the overall plan of care for participants on their caseloads. In reviewing some participant plans of care, there were inconsistencies noted between what is stated in the plan of care related to medical/psychological concerns, level of supervision, and needed supports.

Case management monthly/quarterly notes contained the required documentation components consisting of documentation of home visits including at least 60 minutes of

direct service with the participant and guardian, monthly tracking of billing and units, follow-up on concerns noted and quarterly documentation requirements. While case managers reported regular follow-up on incident reports and met weekly with psychological staff to review incidents the specific follow-up done by the case managers regarding incident reports was unclear.

Exemplary Practices:

- None

Commendations:

- None

Suggestions:

- None

Recommendations:

It Is Recommended That MRSI Submit A Quality Improvement Plan by October 8, 2007 for the Following Areas Of Non-Compliance:

Evanston

- The case managers at the Evanston site are not consistently monitoring services on participants' plans of care, tracking and reporting progress on objectives, documenting follow up on concerns and incident reports in the ISC monthly documentation, or documenting changes to the IPC, communication with the team, and other types of interactions in the ISC monthly documentation (Wyoming Medicaid rules Chapter 45, Section 7, Developmental Disabilities Division rules, Chapter 1).
- The case managers at the Evanston site are not consistently advocating for the preferences and choices of the participants or coordinating with the team in the development of the plan of care (Developmental Disabilities rules, Chapter 1, section 10).

Cheyenne

- The case managers at the Cheyenne site are not assuring that the individual plans of care are written and implemented in a consistent and cohesive manner, resulting in contradictory information within the plans concerning medical needs, psychological needs, behavior support plans, levels of supervision, needed supports, rights, and restrictions (Developmental Disabilities rules, Chapter 1, Section 12 and 13).

Agency Wide

- The organization's case managers are submitting plans of care for participants, which have been approved by the Division, that include objectives that are not measurable and meaningful and therefore the organization must work with the appropriate waiver staff to develop a plan to address this concern (Wyoming Medicaid rules Chapters 41, 42 and 43 Section 9).

Lead Surveyor _____ Date _____